Date:	August 14, 1998	DSL-BQA-98-042
To:	Nursing Homes	NH- 24
	Hospitals with Swing Beds	HOSP 16
	Hospices	HSPCE 14
From:	Judy Fryback, Director Bureau of Quality Assurance	

Resident Assessment Instrument (RAI) and Minimum Data Set (MDS) Automation and Announcement of OASIS Informational Program

This memo addresses the current status of Minimum Data Set (MDS) automation and the Resident Assessment Instrument (RAI). If you have any further questions regarding these issues, please contact Billie March, RAI Coordinator, at (608) 266-7188, or Richard Betz, MDS Automation Coordinator, at (608) 264-9898. It also gives a brief update on OASIS – the home health data set.

Exhibits attached to this memo:

1. Key Field Correction Form
2. Overview of MDS 2.0 Correction Policy – (graphic)
3. Resident Census and Conditions of Residents Form and Provider Instructions
4. Roster/Sample Matrix Form and Provider Instructions

Federal MDS Requirement

If you are a certified Medicare and/or Medicaid nursing facility, then you must complete, record, encode, and transmit the MDS (Minimum Data Set) for all the residents in your facility, regardless of age, diagnosis, length of stay, or payment category. Failure to complete and transmit the MDS will be considered noncompliance with a Medicare and/or Medicaid Requirement of Participation (42 CFR 483.20), and may result in an enforcement action. Only assessments completed on or after June 22, 1998 are subject to this requirement. There is no requirement to encode or electronically transmit assessments that were completed prior to that date, even if residents for whom those assessments were completed continue to reside in the facility after June 22. For these residents, subsequent assessments must be submitted.

Internet References

Current information about MDS and Prospective Payment System (PPS) requirements can be obtained electronically from the INTERNET. In addition, information will also be posted at the Bulletin section on the MDS system. Important INTERNET addresses include:

MDS information:

http://www.hcfa.gov/medicare/hsqb/mds20

Medicare PPS information:

http://www.hcfa.gov/medicare/snfpps.htm

Wisconsin - State information:

http://www.dhfs.state.wi.us/reg_licens/index.htm

Medicare Prospective Payment System

You can locate and download information about the Medicare Prospective Payment System (PPS) at the HCFA web site (see section above).

Two documents that are important to your understanding of the PPS requirements are:

1) Federal Register, May 12, 1998, 42 CFR Parts 409, et al. Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Final rule; and
2) ***Medicare Provider Reimbursement Manual,*** July 1998.

Section T- Therapy Supplement for Medicare PPS

Section T – Therapy Supplement for Medicare PPS provides information on special treatments and therapies not reported elsewhere in the MDS. Information about coding Section T is in the Long Term Care Resident Assessment User's Manual,
Chapter 3 – pages 168-175.

Section T must be completed with each Medicare PPS assessment. In the case of a Medicare 5-day assessment, the clinician captures minutes of therapy that are *anticipated* for the patient/resident during the first 15-days of his/her nursing home stay. This makes it possible for the patient/resident to classify into the appropriate RUG (Resource Utilization Group) rehabilitation group based on his/her anticipated receipt of rehabilitative therapy. The Medicare 5-day assessment is done during the first few days of the SNF stay and there has not been enough time to provide more than the beginning of a course of rehabilitative therapy. The RUG grouper takes into consideration both the days and minutes already received by the patient/resident as reported in Section P- Special Treatments and Procedures and the days and minutes expected to be received in the first 15 days of the nursing home stay. The number of days and minutes *expected,* as reported in Section T should include those already received during the assessment reference period and coded at Section P.

Section T1b of the MDS, the item in which expected therapy is reported, may only be completed for the 5-day Medicare required assessment or on a Medicare readmission/return assessment (AA8b and A8b is coded 1 or 5). On subsequent PPS assessment, i.e., Medicare 14-day assessment, Medicare 30-day assessment, Medicare 60-day

assessment and Medicare 90-day assessment, pay attention to the skip instructions at Section T 1 – *Skip unless this is a Medicare 5-day or Medicare readmission/return assessment.*

Medicare Swing Bed Hospitals

As indicated in the federal Balanced Budget Act (BBA) of 1997 there will be a transition to a Prospective Payment System (PPS) for skilled nursing facility services in Swing Bed Hospitals. The PPS will be based on MDS data. The federal Health Care Financing Administration (HCFA) is currently developing the requirements for this transition. These requirements will not go into effect before July 1, 1999. No further information is available at this time.

The Bureau of Quality Assurance (BQA) memos on MDS are being sent to Swing Bed Hospitals to provide current information about MDS issues.

Role of Hospice in MDS

In collaboration with the nursing facility, the hospice provider will conduct an assessment of the patient and their family/caregiver needs as a whole. The information contained in the resident assessment instrument (RAI), completed according to the nursing home requirements, needs to be considered in the assessment process. The nursing home and hospice must coordinate, establish and agree upon a plan of care for both providers that reflects the hospice philosophy. Within a formal agreement, the guidelines and protocols need to define the role of each provider in assessment, development, implementation, evaluation and updating of this individualized coordinated plan of care.

MDS Errors and Correction Policy

There are three types of errors that facilities may encounter when submitting MDS data to the state system: (1) **fatal file errors,** (2) **fatal record errors** and (3) **non-fatal errors**.

Fatal file errors result in rejection of the entire file (batch status "Rejected" on the Initial Feedback Report). **Fatal file errors** include missing, mismatched, or invalid Facility ID numbers in the header record or individual resident records, missing header or trailer records, invalid data in the Record ID field, and a space or null value in the AA8a (primary reason for assessment) field.

Fatal record errors (number of records rejected greater than 0 on the Initial Feedback and Final Validation reports). **Fatal record errors** result in rejection of one or more individual resident records. **Fatal record errors** include invalid AA8a/AA8b combinations, lack of resident identifying information (name, gender, birth-date, race/ethnicity, assessment reference date), and duplicate assessments (attempting to resend an assessment that has already been submitted to and accepted by the state system).

Non-fatal errors do not result in rejection of a record. **Non fatal errors** include missing or questionable data of a non-critical nature, record sequencing and timing errors, record locking errors and field consistency errors. **Non-fatal**

errors are reported to the facility in the "Final Validation Report." (Non fatal errors were referred to as *data integrity errors* in earlier print materials.)

Fatal file errors and **fatal record errors** require that the facility correct the error(s) and resubmit the records as appropriate by the required date (i.e. within 31 days of the final lock date). If a submission contained a fatal error(s) in some records and the remaining records were accepted, you cannot resend the same file, because the accepted records have already been loaded into the state database and resubmitted records will be rejected as duplicates. Only the records that were rejected due to fatal record errors can be resubmitted (after the corrections are made).

Non-fatal errors in locked records can be classified as either **KEY field errors** or **non-KEY field errors**. The correction procedures facilities should follow are described below.

Correction Policy for KEY Field Errors in Locked Records

Refer to the attached flowchart "Overview of MDS 2.0 Correction Policy."

When facility staff detect an error in a locked MDS record, they must first determine whether the error is in a *KEY field*. *KEY fields* include important resident and facility identifiers, dates and disposition information. *KEY fields* in the MDS version 2.0 were identified in BQA Memo DSL-BQA-98-037, on the Key Field Correction Form and at the HCFA MDS website:

http://www.hcfa.gov/medicare/hsqb/mds20

To correct an error in a *KEY field* in an MDS record in the State database, the facility must submit a **Key Field Correction Form** (Exhibit 1 attached) to the State, indicating both the "submitted-incorrect" and the "corrected" values(s). State staff will review the request and correct the record in the State database. The facility must have a method to assure that subsequent assessments include the corrected data value. *KEY field* changes may be requested by the facility at any time, but should be submitted as soon as possible after the error is detected.

Please note that the Primary Reason for Assessment (Item AA8a), Other Reason for Assessment (Item AA8b), and the Date RN Assessment Coordinator Signed as Complete (Item R2b), though Key Fields, cannot be changed with this procedure. If these fields are in error a Significant Correction assessment must be completed.

When an MDS record is rejected by the Standard MDS system at the State due to an error in *a KEY field*, the facility may unlock the record, correct only the *KEY field* error(s), and relock the record, using a new lock date, and retransmit the record to the State.

Correction Policy for Non-Key Field Errors in Locked Records

When facility staff detect an error in a locked record that is not a key field, the procedure for correcting the error depends upon the significance of the error and the resident's status at the time the error is discovered. If the error(s) is "**major**"-- that is, it results in misrepresentation of the resident's clinical status--the facility must determine whether the resident's status has changed since the assessment reference date (Item A3a) of the record containing the error. If the resident's status has changed, a *Significant change in status assessment* (Section AA 8a 3 & Section A 8a 3) must be

completed. If the resident's status has not changed, a *Significant correction of prior assessment* (Section AA 8a 4 or 10 & Section A8a 4 or 10) must be completed.

Non-major errors need to be corrected prior to the next scheduled MDS record submission.

Facility staff makes the determination as to whether the error is major. Documentation in the medical record to support this decision is important.

MDS Forms

The Wisconsin Department of Health and Family Services will not be providing paper MDS forms, except for Section S. Wisconsin has specified that it will use HCFA's MDS forms with the addition of Section S, State Supplemental Items. The federal MDS forms can be copied and used, or copies of the MDS can be generated from the facility's MDS software. A copy of the required MDS forms (MDS 2.0 01/30/98) was provided with the memo DSL-BQA-98-018, April 17, 1998.

If a clean paper copy of the MDS forms is needed please contact Billie March at (608) 266-7188.

Copies of the HCFA MDS forms can also be obtained from the HCFA MDS web site at:

http://www.hcfa.gov/medicare/hsqb/mds20

Background (Face Sheet) Information at Admission Form

If a resident is permanently discharged, (*Discharge Tracking Form*, Section A 8, Reason for Assessment, is coded as a 6-Discharged-return **not** anticipated, and then comes back to the facility, a new ***Background (Face Sheet) Information at Admission*** form must be completed.

HCFA's clinical policies, as well as data specifications, allow *Face Sheet* information to be updated and submitted after the admission assessment is completed and transmitted. Facilities must submit the **MDS Version 2.0, 1/30/98; *Background (Face Sheet) Information at Admission*** form with the first MDS record that is transmitted for each resident on or after June 22, 1998. If the first MDS record that was transmitted did not contain the resident's ***Background (Face Sheet) Information at Admission*** form, the record should be submitted with any next record submission for that resident.

Day of Admission is Day-One

The day of admission is day one for MDS assessments and Medicare PPS assessment. This is a change from the 1995 requirements when the day of admission was considered to be day-zero.

Coding Therapies

Q.: When coding at Section P 1 b Therapies, how does a facility account for therapy provided to an individual when the therapy is given within a group setting?

A.: Although HCFA recognizes that receiving physical, occupational or speech therapy as part of a group has clinical merit in a selected situation, services received within a group setting should not account for more than 25 percent of the Medicare patient's therapy regimen during his/her SNF stay. The minutes of therapy provided by at least one supervising therapist (or therapy assistant) within a group of four or fewer participants, may be fully counted, provided that those minutes account for no more than 25 percent of the patient's (resident's) weekly therapy as reported in Section P on the MDS. The supervising therapist may not be supervising any individuals other than the four or fewer individuals who are in the group at the time of the therapy session.

All therapy services must meet each of the following criteria in order to be coded on the MDS as rehabilitative therapy at Section P and/or Section T:

- A physician must order the service.
- The therapy intervention must be based on a qualified therapist's evaluation and plan of care as documented in the resident's record.
- An appropriate licensed or certified individual must provide or directly supervise the therapeutic service and coordinate the intervention with nursing service.

Q.: When coding therapies at Section P, Special Treatments and Procedures, the directions instruct the assessor to look back over the "last 7 calendar days," (the Assessment Reference Date, Section A3 identifying the last date of the reference period) counting only post admission days and minutes of therapy. Are the seven (7) calendar days consecutive days?

A.: Yes, by definition calendar days are consecutive days.

Coding *Roster/Sample Matrix* – HCFA-802 (6/98)

There is no federal requirement for automation of the HCFA-802 form. The HCFA-802 is designed to be a representation of current resident status according to the definition of the HCFA-802 during the time of the survey. The facility may use the MDS data to start the HCFA-802 form, but must verify all information, and in some cases, re-code the item responses to meet the intent of the HCFA-802.

Attached to this memo is a copy of the ***Roster/Sample Matrix* – HCFA-802** (6/98) and instructions for using MDS data in completing the form.

Coding *Resident Census and Conditions of Residents* – HCFA-672 (6/98)

There is no federal requirement for the automation of the HCFA-672 form. The HCFA-672 is designed to be a representation of the facility during the survey; it does not directly correspond to the MDS in every item. Facilities may use the MDS data to start the HCFA-672 form, but must verify all information, and in some cases, re-code the item responses to meet the intent of the HCFA-672 to represent current resident status according to the definitions.

Attached to this memo is a copy of the ***Resident Census and Conditions of Residents Form***, HCFA-672 (6/98) and instructions for using MDS data in completing the form.

Medicare Demand Billing

The federal requirements for Demand Billing have not changed. Demand bills should be submitted indicating the beneficiary requested the non-covered claim to be submitted by the skilled nursing facility (SNF) to the fiscal intermediary (FI) for consideration and approval after the beneficiary was issued a written notice of noncoverage by the SNF. The Health Insurance Prospective Payment System (HIPPS) rate code(s) must be present on the demand bill. This requires that the SNF perform an assessment of the beneficiary in order to classify beneficiary for purposes of payment. A SNF does not have to classify a beneficiary into a RUG group if he or she does not meet the eligibility requirement for a three-day hospital stay. When disposition of the demand bill has been completed, and if the demand bill is approved, it will be paid based on the HIPPS rate code corresponding to the RUG group(s) the resident was in for the approved covered days. When the FI determines during its review of the associated medical documentation that the medical record does not support the level of services billed (e.g., review of the MDS, nursing and therapy documentation does not support the medical necessity or appropriateness of care reflected in the billed HIPPS rate code) the FI denies the demand bill. If the beneficiary disagrees with the FI's denial of the demand bill, the beneficiary has the right to appeal the determination.

HCFA's State Operations Manual (SOM)

Facilities can access a draft of the Health Care Financing Administration's SOM at the HCFA web site:

http://www.hcfa gov/medicare/hsqb/mds20

The SOM is HCFA's guidance to the State in carrying out the MDS data collection. A copy of the final issuance of the SOM will be mailed to all nursing facilities when it is available.

Long Term Care (LTC) Resident Assessment Instrument (RAI) Users Manual Edit – April 1998

The Bureau of Quality Assurance has updated the **Long Term Care (LTC) Resident Assessment Instrument (RAI) Users Manual**, Version 2.0, 1995 with the new 1/30/98 MDS forms and the corrections HCFA identified in the errata-sheet report. The main content of the manual; the utilization guidelines, coding definitions and the Resident Assessment Protocols (RAPs) have not changed.

A page correction is attached to this memo. Those of you who received a copy of the April 1998 edited version of the Long Term Care RAI Users Manual at the recent RAI workshops should replace the page indicated. A copy of the ordering instructions is attached to this memo.

OASIS Home Health Data Set For Your Information

OASIS – The **O**utcome and **AS**sessment **I**nformation **S**et is a group of data elements that: represent core items of a comprehensive assessment for an adult home care patient; and form the basis for measuring patient outcomes for

purposes of outcome-based quality improvement (OBQI). The OASIS is a key component of Medicare's partnership with the home care industry. For more information, see the HCFA website at:

http://www.dhfs.gov/medicare/hsqb/oasis/oasishmp.htm

HCFA will be sponsoring a satellite broadcast about OASIS on August 20, 1998, from 12:00 - 2:30 p.m. If you would like information about the locations for this satellite broadcast, please contact Curtis Wittwer at (608) 266-9432.